TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
ST DAVIDS MEDICAL CENTER

**Respondent Name**
CASTLEPOINT NATIONAL INSURANCE

**MFDR Tracking Number**
M4-15-2222-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
March 20, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "[Injured employee] was treated at the Hospital for inpatient rehabilitation on July 30, 2014 through August 26, 2014 and incurred total billed charges in the amount of $87,617.80. Pursuant to Texas Administrative Code §134.1(e)(3), the Hospital is entitled to reimbursement for [Injured employee] treatment at a fair and reasonable amount. The Hospital believes a fair and reasonable reimbursement amount for [injured employee] treatment is 100% of billed charges. To date, the Hospital has been paid only $29,632.91 by Curavita on behalf of the worker's compensation carrier, which we believe to be Tower Group ("Carrier"), leaving an underpayment of $57,984.00."

**Amount in Dispute:** $57,984.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Requestor billed for inpatient hospital rehabilitation. The documentation supplied by Requestor includes a report from Thomas A. Hill, M.D. Dated 7/30/14 which states "the patient requires a comprehensive inpatient rehabilitation program." Requestor now claims the Claimant's admission was outpatient, seeks outpatient hospital reimbursement under DWC Rule 134.403, and opines they should be paid at 100% of billed charges and not limited to the fee schedule amounts; however, that is contradictory to the services documented as provided and to the services billed."

**Response Submitted by:** Downs Stanford, P.C.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 30, 2014 through August 26, 2014 | Inpatient Hospital Services | $57,984.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - 224 – Duplicate charge
   - 802 – Charge for this procedure exceeds the OPPS schedule allowance
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
   - 5300 – Denying charges due to no medical documentation to support the charges. Please forward the medical documentation along with the medical bill

**Issues**

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

**Findings**

Review of the submitted documentation finds the disputed charges relates to inpatient acute care charges. The Requestor states in it's position statement "Pursuant to Texas Administrative Code §134.1(e)(3), the Hospital is entitled to reimbursement for [injured employee] treatment at a fair and reasonable amount. The Hospital believes a fair and reasonable reimbursement amount for [injured employee] treatment is 100% of billed charges". Therefore, the dispute will be reviewed in accordance with 28 Texas Administrative §134.404.

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 143 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 945. The services were provided at ST DAVIDS MEDICAL CENTER. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $9,657.03. This amount multiplied by 143% results in a MAR of $13,809.55.

3. The total recommended payment for the services in dispute is $13,809.55. This amount less the amount previously paid by the insurance carrier of $29,937.91 leaves an amount due to the requestor of $0.00.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

## *ORDER*

**Authorized Signature**

| | | |
|---|---|---|
| | | 5/15/15 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 5/15/15 |
| Signature | Medical Fee Dispute Resolution Manager | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.